REPORT OF TARGET EXAMINATION
PacifiCare of Washington
As of June 24, 1996

PacifiCare of Washington

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PacifiCare of Washington

Memorandum to Chief Examiner

To: **Jacqueline L. Gardner, CFE, FLMI**
Chief Insurance Examiner

From: **Michael V. Jordan, CPA, CFE**
Examiner in Charge

Subject: **Target Examination of PacifiCare of Washington**

Date: **August 2, 1996**

Examination Team: **Michael Jordan, Examiner in Charge**
Leslie Krier, FLMI, Market Conduct Examiner

Pursuant to your instructions and in compliance with the requirements of the state of Washington, a target examination has been made of the corporate affairs and financial records of PacifiCare of Washington in Seattle, Washington, hereafter referred to as the "Company" or "PCW" at its home office, located at 7525 SE 24th, Mercer Island, Washington 98040.

The Objectives of our target examination were as follows:

1. Review and assess quality of management.
2. Determine the adequacy of internal controls and the reliance that can be placed on the Company's accounts and records.
3. Assess the Controls in place for Electronic Data Processing systems (EDP).
4. Review and assess operations for compliance with state regulations pertaining to consumer policy and benefits.
5. Review Company compliance with Washington State statutes and National Association of Insurance Commissioners (NAIC) regulations pertaining to the compilation and reporting of the annual statement.
6. Gain a level of comfort for overall ability and expertise in health care operations.
7. Review correspondence between the Office of the Insurance Commissioner (OIC) and the Company to determine areas in need of closer review and analysis.

Scope

Our target examination included the business affairs and financial condition of the Company for the period ended June 24, 1996. The examination was performed in accordance with procedures promulgated by the NAIC for limited scope examinations and in compliance with the provisions of Washington State insurance laws and regulations.

Findings and Instructions

1. Indemnity Deposit

We recommend the Company consolidate the securities on deposit with one bank and also instruct the Company to increase its securities on deposit to the required minimum amounts per RCW 48.44.030. In addition, the name on the accounts is Network Heath Plan, Inc., which should be changed to PacifiCare of Washington.

2. Negotiated Contracts

The Company is required to file all negotiated contracts within 30 days of the date the negotiations with the group are completed. This requirement applies to contracts, riders, endorsements and rates, as set forth in WAC 284-44-130(2). Negotiated group contracts from mid 1994 through mid 1996 were not filed in accordance with the regulation. The reason given for this oversight was a lack of staff who were able to perform this function, and extra workload created by mergers with other health care service contractors. All groups were filed in May of 1996, and a follow up system has been established to ensure that timely filing occurs in the future.

3. Member Handbooks

The member handbook, MH-1 does not include language required by WAC 284-51-150(2). This regulation requires companies to include a statement in the coordination of benefits section of the handbook that instructs members to file claims with all carriers simultaneously. The Company is instructed to include this language in all member handbooks.

4. Board Ratification of Investments

Review of the Company's Board of Directors' Minutes did not disclose the approval or ratification of the sale and acquisition of investments as required under RCW 48.13.340. The Company is instructed to document investment activity in the Board Minutes on a regular basis.

5. Claims

A review of claims indicated the Company is not in compliance with the coordination of benefits provision under WAC 284-51-100. The Company is instructed to change the coordination of benefits process to comply with WAC 284-51-100 which requires a company to pay as primary coverage if, after a reasonable period of time, the information needed to determine secondary payment and coverage is not received. Currently, the Company denies the claim if the primary coverage information is not received within a reasonable period of time.

6. Custodial Agreement

A review of the custodial agreement with First Interstate Bank disclosed that the agreement did not conform to NAIC requirements which state that the bank or trust company as custodian is obligated to indemnify the insurance company for any loss of securities of the insurance company in the bank or trust company's custody. The bank or trust company shall not be so obligated to the extent that such loss was caused by other than the negligence or dishonesty of the bank or trust company. The Company is instructed to revise the custodial agreement with First Interstate Bank to include the indemnity clause required by the NAIC.

7. The 1995 Actuarial Certification

The 1995 Actuarial Certification was reviewed for compliance with the NAIC *Annual Statement Instructions*. Two provisions were not included as required. The Company is instructed to require the Certification to attest to the adequacy of the following:

a.) Unearned premiums ($12,335,077), Per NAIC *Annual Statement Instructions,* Page 7, 5D.

b.) IBNR unpaid claim adjustment expense Per NAIC *Annual Statement Instructions,* Page 7, 5A. Only reported claims (Case Reserves) claim adjustment expenses were included in the report.

8. Schedule "Y"

Parts 2, 3 & 4 should have been filed with a summary of transactions with affiliates. The Company has intercompany agreements with PacifiCare Benefit Administrators, PacifiCare Health Systems and PacifiCare of Oregon for various service and support functions.

9. Statutory Reserve

The Statutory reserve line under Reserves And Special Funds should have listed the indemnity required as calculated under line 39a. of the Additional Data to the Annual Statement.

10. Claim Reserves

After six months of claim development in 1996 for claims incurred in 1995, the Claims Unpaid reserve established by the Company for its indemnity business was determined to be approximately $2.5 million dollars deficient. The Company is instructed to develop reserves that are adequate to cover all claims unpaid.

11. Exhibits 5, 6 and 7

Exhibits 5, 6 and 7 were incorrectly completed. The NAIC Annual Statement Instructions, page 51 indicate "In the event that the corporation provides either hospital, medical or dental coverage, separate exhibits should be shown for each." The Company supplies medical, dental and hospital coverage, but consolidates them all under medical.

Recommendations

1. Provider Contracts

The examination consisted of a review of the provider contracts currently in use. A sample of fourteen provider contract files was reviewed to ensure that only approved contract forms had been used in contracting. All contract forms in use contain a separate page that has been approved by the OIC that contains all language mandated by WAC 284-44-240. There were no instances where an unapproved form was in place. In addition, the Company files provider listings and updates as required by RCW 48.44.080.

The only area of concern was that the Company was unable to produce a complete listing of contracted providers for review during the examination. The listing was produced and filed with the Annual Statement as required, but it was not saved and could not be reproduced during our examination. It is recommended that the procedures used to produce this report be recreated and saved. The Company has a responsibility to produce this information for regulators, employer groups and members upon request.

2. Claims

It appears that not all processors are handling subrogation cases in the intended manner. It is recommended the Company institute additional controls and training to ensure all subrogation is processed according to the established guidelines. Consequently, subrogation cases will be investigated and any monies due will be recovered for the benefit of the Company and its subscribers.

During the claim review, it was noted that benefits for a new group did not get updated on the system prior to the first claims being received. Usually, the marketing area provides a sheet outlining the contract benefits for the claims processors when this happens. However, in this case, the information given to claims was incomplete, as was the information entered into the system. The result was that claims were paid in full when a copayment should have been charged. The Company decided that because complete benefit information was not available at the time of the claim, the additional cost to the member was waived. This practice could be costly to the Company if it is allowed to continue for any length of time. Since routing information is a communication issue between two units, and these units will soon reside in different offices, it is imperative that the Company develop procedures for sharing benefit information between these two areas, and to have this information passed from marketing to claims prior to the time that the first claim is received.

3. Unpaid Claims Adjustment Expenses

An analytical review of unpaid claim adjustment expenses was performed to determine the adequacy of the provision established for this liability. It was determined that the Company's provision for unpaid claim adjustment expenses was probably deficient. The Company has reserved approximately one half of one percent of its claim reserves. A four to six percent provision would be more reasonable and comparable with the health care industry.

In the 1995 Annual Statement, Underwriting and Investment, part 3, Analysis of expenses, indicates the percentage of actual claim adjustment expenses to paid claims for 1995 is approximately one percent. This also appears to be deficient given industry averages. It is recommended the Company review its allocation methodology to determine if it has correctly identified and captured all claim adjustment expenses.

4. Contracts

Several contracts for administrative and other functions were found to be unsigned and in the names of previously acquired companies, as well as located in various geographical locations. It is recommended the Company consolidate its contracts, change the company name to PacifiCare of Washington and maintain controls to ensure all contracts are signed in a timely manner.

Conclusion

In 1994, the Company underwent significant transitions that caused growing pains that are still requiring the Company to divert substantial resources and time to correct. The following are some of the more important transition issues the Company has encountered:

1) Network Health Plan (NHP) was purchased by PacifiCare Health Systems in February 1994 and became PacifiCare of Washington (PCW).

2) Appointment of a new CEO/President and restructuring of Senior Management.

3) Regionalization of PCW and PacifiCare of Oregon (PCO).

4) Expanded Medicare contract into four new counties; Pierce, Cowlitz, Lewis and Thurston.

5) Began shifting network from fee for service to capitation model.

The Company appears to have taken a proactive stance in identifying corporate goals and correcting the problems that have materialized due to significant growth. The following is an excerpt from the Board Minutes of the more significant problems the Company has identified and taken action to correct:

> "For example, modifications to our existing information systems to accommodate capitation have not worked as planned, causing inaccurate payments to providers, improperly processed claims, etc. Claims processors have not been adequately trained and have exacerbated the problems with an inordinate number of mistakes. This, in turn, has increased the volume of calls to member services resulting in 20 minute hold times, claims backlogs due to need to re-process claims and provider dissatisfaction with our administration of the contracts. The providers' lack of understanding of their contracts and inexperience with capitation have compounded our problems."
>
> "At the same time, we have increased our membership and been unable to hire staff fast enough to manage our growth (50 vacant positions or 22% of the budgeted work force). Consequently, staff morale is very low due to customer dissatisfaction and in some cases, overwork and/or mandatory overtime is necessary in order to keep up. In essence, all systems and staff in the company have been stretched to their limits."

The Company is in the process of correcting the problems it has identified and appears to be committed to resolving them and delivering a quality health care product to consumers. Based on

this limited scope examination, we have gained assurance that the Company is a well managed and soundly financed Health Care Service Contractor. It appears to be committed to delivering health care services in a fair and equitable manner. In our opinion, the Company is not a high priority examination and we recommend it be scheduled for a full scope examination in the normal course of scheduling exams.

I. CORPORATE MANAGEMENT AND RECORDS

Concentration of Ownership

PacifiCare Health Systems, Inc. (PHS), a Delaware corporation, is the parent and sole shareholder of PacifiCare Benefit Administrators which is the sole shareholder of PacifiCare of Washington. PHS is a publicly traded company on the over-the-counter market quoted on the NASDAQ exchange. PHS has two classes of stock; class A voting and class B non-voting.

As of March 1995, UniHealth American, a California non-profit public benefit corporation, owned approximately 48% and 9% of PHS' outstanding shares of class A and Class B common stock, respectively.

PHS is listed as the ultimate parent for thirty-seven affiliated companies which includes PacifiCare of Washington. The majority of these companies are health, dental and other health related companies predominately located in the Western region of the United States. The Company does not voluntarily file Holding Company disclosures with the Insurance Commissioner.

Board Members and years of service with the Company

Jeffrey Folick, E.V.P., COO, PHS	1 year
Wayne B. Lowell, E.V.P., C.A.O., CFO, PHS	2 years
Mary McWilliams, President/CEO, PCW	2 years

Company Officers' years of service with the Company

Mary McWilliams, President & CEO	2 years
Maureen McLaughlin, Vice President, General Manager	1 years
Lori Mitchell, Vice President, Finance and Strategic Planning	6 years
Daniel L. Kent, MD, Medical Director	3 years
Brian J. Jeffrey, Vice President, Provider Services	1 1/2 years
Mimi Haley, Director, Regulatory Affairs	6 months
Kathy Major, Interim Director, Operations	1 year
Anne Golden, Director, Human Resources	9 months

Conflict of Interest questionnaires were reviewed for all Board members with no conflicts noted.

Directors' and Officers' Liability insurance is written through National Union Fire Insurance Company for a maximum aggregate coverage of $10 million dollars.

Corporate documents

Pursuant to RCW 23B.10.020, the Company amended the Network Health Plan, Incorporated Bylaws and Articles of Incorporation, as of September 21, 1994, to make PacifiCare of Washington, Incorporated the named company.

Annual statement review

Review of the 1995 Annual Statement filing disclosed several deficiencies the Company is instructed to correct with future filings. The following is a list of those deficiencies:

1. Actuarial report

    a.) No provision for unearned premiums ($12,335,077). Per NAIC *Annual Statement Instructions,* Page 7, 5D.

    b.) No provision for IBNR unpaid claim adjustment expense Per NAIC *Annual Statement Instructions,* Page 7, 5A. Only reported claims (Case Reserves) were included in the report.

2. Schedule "Y"

    Parts 2, 3&4 should have been filed with a summary of transactions with affiliates. The Company has intercompany agreements with PacifiCare Benefit Administrators, PacifiCare Health Systems and PacifiCare of Oregon for various service and support functions.

3. Exhibits 5, 6 and 7

    Exhibits 5, 6 and 7 were incorrectly compiled. The NAIC Annual Statement Instructions, page 51 indicate "In the event that the corporation provides either hospital, medical or dental coverage, separate exhibits should be shown for each." The Company supplies medical, dental and hospital coverage, but consolidates them all under medical.

4. Statutory Reserve

    The Statutory reserve line under Reserves And Special Funds should have listed the

    indemnity required as calculated under line 39a. of the Additional Data to the Annual Statement.

5. Surplus note interest accrual

The Company's Surplus Note with PacifiCare Health Systems does not allow the accrual or payment of interest without written approval of the Insurance Commissioner. The 1995 Annual Statement lists an interest accrual on the Surplus Note of approximately $1.5 million dollars. The Company is instructed to obtain approval to accrue the interest or omit it from the annual statement entirely.

Administrative and other Contracts

Our review of administrative contracts indicated that the Company does not maintain signed copies of all contracts at its home office. In some instances, the Company had to request copies of administrative contracts from PHS. We recommend the Company maintain current signed contracts at its home office for all administrative services. The following is a list of significant contracts in force during 1996:

Surplus Note and Escrow Agreement

The Company entered into Subordinated Surplus Note with PacifiCare Health Systems for a revolving $40 million dollar line of credit in April 1995. To date, $30 million is outstanding on the note. An escrow agreement and solicitation permit were required by the Insurance Commissioner's Office. The Company has complied with the terms of the solicitation permit except as to the accrual of interest.

Reinsurance Agreement

Carrier:	John Alden Life Insurance Company
Current Contract Year:	7/1/95 through 6/30/96
Covered Members:	Commercial and Point of Service, excludes capitated members
Annual Deductible:	$175,000 per member per contract year for commercial and point of service members $ 25,000 per member per contract year for Healthy Options Medicaid members
Reimbursement:	80%
Limitations:	No Inside Daily Limit
Insolvency Coverage:	$5,000,000 Aggregate Maximum Liability

Administrative Services Contracts

Public Hospital District #2 Snohomish County, D.B.A. Stevens Memorial Hospital. The period of this contract is 1/1/96 through 12/31/96 and covers the administrative functions to

be performed by PacifiCare of Washington. According to the Company, this is the only administrative service contract currently in place.

Snohomish County Employees. This group terminated 6/30/96, but had terms similar to the Stevens Memorial Hospital contract.

Intercompany Agreements

Amended and Restated Administrative and Marketing Services Agreement This agreement was originally signed 4/12/90 between Network Management, Inc. (NMI) and Network Health Plan, Inc. (NHP). The original effective date was 7/1/89. In 1994, the names of the entities changed to PacifiCare Benefit Administrators (NMI), and PacifiCare of Washington (NHP). The agreement outlines the specific services to be performed by NMI on behalf of NHP. We recommend this contract be updated to reflect the current names of the parties.

Administrative Services Agreement This agreement is between PacifiCare of Washington (PCW) and PacifiCare Health Systems (PHS). The effective date of the agreement is October 1, 1993 and the agreement was signed 2/1/94. It outlines the services to be performed by PHS on behalf of PCW, the means of compensation for these services, and the contract period.

Administrative Services Agreement (Proposed) This agreement will outline the duties to be performed by PacifiCare of Washington and PacifiCare of Oregon in a combined administrative effort. It outlines the duties for each company and compensation for each company. The agreement is not in effect yet.

Administrative Service Agreements

The Company has contracts for services with the following companies to administer parts of the benefit packages for PacifiCare of Washington. The contracts were not reviewed as a part this examination.

PacifiCare Behavioral Health (PBHI) This contract is for the purpose of administering mental health and chemical dependency benefits for PCW contracts.

Chiropractic Network Service (CNS) This contract is to administer the chiropractic benefit for the CNS network chiropractors used with some PCW contracts.

Vision Service Plan (VSP) This contract rents the VSP Vision network and administration of vision claims.

Diversified Pharmaceutical Service (DPS), and Prescription Solutions Inc. (PSI) are both

vendors for pharmacy benefits and networks that are used by some PCW groups.

Vista Optical and Eye Care of Washington are vendors for vision services used by some PCW groups.

II. Financial Findings and Comments

Fluctuation Analysis

The objective of Fluctuation Analysis is to review the Financial Statements of the period under examination for any unusual variances in reported balances between years and determine if a reasonable explanation for the variance exists.

The examination covered the Financial Statements for 1994 and 1995, the only years the Company has filed. A questionnaire was submitted to the Company for explanation of the variances. The explanations provided by the Company appear to reasonably explain the variances in the reported balances between years.

Internal Controls

The Company's parent PHS maintains an internal audit department that is responsible for the internal audit function of PHS and its subsidiaries. The Internal Audit Department was established by the Audit Committee of the Board of Directors of PHS. The Director of the Audit Department reports administratively to the Chief Financial Officer and functionally to the Audit Committee.

General journal entries other than standard entries are authorized by a responsible official not involved in the origination of entries.

Access to accounting and financial records is restricted to authorized personnel through physical segregation and system restrictions. Internal control procedures are written and appear to safeguard the Company's assets. We reviewed a sample of internal control procedures for compliance without material exception.

PacifiCare of Washington

Receipt Analysis

The Receipt Analysis and Disbursement Analysis sections of this report will be documented for the period of the target examination, but reliance on the work performed by Ernst & Young will be utilized almost entirely due to the fact the Company is in the process of converting to two new systems for disbursements and receipts. The Company currently uses a system called HOBBS which is documented below. By the end of 1997, the Company will be using two systems called NICE and Health Care Processing System (HCPS). According to Andrew Boyd, Regional Accounting Manager, the NICE (internally developed system) will take on all functions listed below for the capitation business and the HCPS (Digital Corp. software) will take on all the functions for fee for service (indemnity) business. It is recommended that when the Company is scheduled for a full scope examination that we document the controls at that time.

The following documentation was extracted from the work performed by Ernst & Young, LLP, on its Commercial Billing, Accounts Receivable and Enrollment Audit Report of June 1995.

Background

PacifiCare of Washington and Pacific Health Plan Accounting Departments are responsible for preparing invoices for billing, collecting premiums and reconciling employer group eligibility statements to cash receipts. The Membership Services Department is responsible for processing enrollments, terminations and dependent coverage changes. The Underwriting Department is responsible for generating quotes and the Marketing Department is responsible for inputting negotiated rates into the system. The Contract Management Department is responsible for maintaining employer group contract files.

Conclusion

Ernst & Young's audit objective was to determine that the commercial billing, accounts receivable and enrollment controls adequately ensure that revenue and receivables are valid and accurate. Its audit report did not disclose any significant financial or internal control issues that would result in a material financial misstatement in the receipts area. We concur with the results of the E & Y audit report.

Disbursement Analysis

The disbursement analysis included claim disbursements only. Capitation and administrative payments were not reviewed as part of our target examination. The Company's auditors, Ernst & Young, LLP, issued a Claims Audit Report as well as a Claims System Documentation Report for the year ended December 31, 1995. For the purposes of our Target Examination we have relied upon the work and documentation of controls performed by Ernst & Young, LLP and verified with interviews with the Company that the controls documented in the report are still applicable for our

examination.

In addition, we conducted a claims audit of approximately 100 randomly sampled claims under the Market Conduct section of this report, where our recommendations are included. The following is a brief overview of the controls in place for claim disbursements:

Receipt of claim

Claims are received in the mail room, date stamped with a Julian date, counted, batched by plan group number and sorted by employer group. Batched claims are then sent to claim processors who specialize in certain types of claims such as Commercial or Secured Horizons. The Company requires the claims to be processed within thirty days of receipt.

Processing, audit and disbursement controls

The processors stamp each line item on the claim to be processed with a sequential number. This number combined with the Julian date and the year become the claim number. Claim information is accessed by entering the subscriber's social security number which identifies the subscriber's plan type through referencing data input by the eligibility department to update the system.

Numerous controls and computer edit functions exist to ensure adequate control over the processing and payment of claims. Some of the more critical controls are:

1. A high dollar hard edit stops the processing of the claim for certain CPT codes in which the claimed charge exceeds the maximum allowable set up for that code. This edit applies to payments to enrollees over $500 dollars, ambulance and other select CPT codes. The pended claim is sent to the lead processor or to the supervisor for approval. The lead or supervisor will then finish processing the claim.

2. A timely filing covenant is normally built into the provider contracts. Generally, contracted provider or commercial claims must be received within six months of the date of service. Medicare claims for non-contracted providers have up to twenty-seven months to file. The timely filing edit disallows further processing without the approval of a supervisor.

3. Anytime a subscriber's profile or claim indicates the coordination of benefits or third party liability the claim is pended and sent to either the Medical Department for pricing or the Subrogation Department for further investigation. If the claim is approved for payment, an approval to pay must be attached to the physical claim document from either of these departments.

4. Segregation of duties between the Eligibility Department, Claim Department and Information Systems (IS) Department are designed to limit *edit* access to the data base to

only each department's area of responsibility. For example, only the Eligibility Department can add or delete subscribers, only the Claims Department can input claims and only the Information Systems Department can make payment on the claims.

5. An internal claim audit is performed every day on claims processed the previous day. The goal of the selection criteria is to have three random claims, of different types, selected per processor, per day. In addition, all claims over $10,000 to providers and all claims over $750 to individuals are subject to 100% audit.

6. The IS Department runs a preliminary cash requirements report which lists in detail all claims processed to be paid. The report is sent to the processors for review and a second report showing all claims over $2,500 is sent to the lead processors and supervisors for additional review. After these reports are reviewed, a cash requirements report is run in a summary format which is kept by the accounting department.

Conclusion

The Company's auditors, E&Y, documented two control weaknesses they felt were not material. First, they were unable to verify some provider contract terms from the Company's system, and secondly, they were unable to test the incurred but not reported (IBNR) liability of Pacific Health Plan (PHP) because the Company could not produce lag models. We were able to obtain lag models for the PHP for our IBNR analysis to our satisfaction. We concur with E&Y on the inability to verify some provider contract terms and also concur that the control weakness would not result in material financial misstatement. The controls in place for claim disbursements are adequate and seem to be functioning as designed. We relied on the controls for the purposes of our target examination.

Investment Analysis

Investment of funds is directed through the PHS Treasury department and performance is measured primarily at the consolidated level of the organization. Capital expenditures are not reported routinely as they are not considered material to the overall picture of the Company.

PHS has a corporate wide policy regarding investment of the Company's assets. It is reviewed and updated on an "as needed" basis, but no less than annually. Investment performance is reported monthly to the Company and PHS management. A review of the Board of Directors' minutes determined that the directors do not approve the purchase and sale of securities as required by RCW 48.13.340, which states:

> "No investment, loan, sale or exchange thereof shall, except as to the policy loans of a life insurer, be made by any domestic insurer unless authorized or approved by its board of directors or by a committee charged by the board of directors or the bylaws with the duty of making such investment, loan, sale or exchange. The minutes of any such committee shall be recorded and reports thereof shall be submitted to the board of directors for approval or disapproval."

Valuation

Bonds are reported at amortized cost and short term investments are recorded at cost. Discount or premium on bonds is amortized using the effective interest method.

Reconciliations

Monthly reconciliations are performed on the following investment accounts:

1. Bonds
2. Certificates of deposit
3. Cash
4. Accrued investment income

Securities on Deposit

RCW 48.44.030 requires a Health Care Service Contractor to place securities on deposit with the State of Washington in the amount equal to the greater of $150,000 or the amount necessary to cover Incurred But Unpaid Reimbursements which is calculated on form IC-13A-HC, Additional Data to the Annual Statement. According to the calculation, the Company should have a minimum reserve deposit of $5,480,506 in the tri-party agreement as of December 31, 1995. The Company actually had approximately $3.4 million held in trust with First Interstate Bank and Key Bank. We recommend the Company consolidate the securities on deposit with one bank and also instruct the Company to increase its securities on deposit to the required minimum amount per RCW 48.44.030.

Safekeeping Agreements

Securities are kept with a non-discretionary custodian, First Interstate Bank of California. A review of the safekeeping agreement disclosed that the agreement did not conform to NAIC requirements, which state:

> "That the bank or trust company as custodian is obligated to indemnify the insurance company for any loss of securities of the insurance company in the bank or trust company's custody, except that, unless domiciliary state law, regulation, or

> administrative action otherwise require a stricter standard (Section 1.b. sets forth an example of such a stricter standard), the bank or trust company shall not be so obligated to the extent that such loss was caused by other than the negligence or dishonesty of the bank or trust company..."

Conclusion

Based on the work performed and information provided, the controls in place for investments appear to be adequate. However, the Company is advised of the following.

1. Purchases and sales of securities are to be approved by the Board of Directors as required by RCW 48.13.340.

2. The custodial agreement should be revised to include the indemnity clause required by the NAIC.

Claim Reserves

An analytical review was conducted of the reserves established for Claims Unpaid and Unpaid Claim Adjustment Expenses. Our review consisted of obtaining actual claims run-off for claims incurred in 1995 and paid in 1996. The run-off was compared to the reserves established by the Company for Claims Unpaid in their 1995 Annual Statement filing. Funds withheld for capitation pools were not tested, but instead we relied on the work of the Company's CPA firm, Ernst & Young, LLP., which did not disclose any deficiencies. The following is a summary of our findings.

Claims Unpaid

Based on a six month claim development in 1996 for claims incurred in 1995, the Claims Unpaid reserve established by the Company for its indemnity business was determined to be approximately $2.5 million dollars deficient for the PacifiCare of Washington fee-for-service business.

Unpaid Claims Adjustment Expenses

An analytical review of unpaid claim adjustment expenses was performed to determine the adequacy of the provision established for this liability. It was determined that the Company's provision for unpaid claim adjustment expenses was deficient. The Company has reserved approximately one half of one percent of their claim reserves.

In the 1995 Annual Statement, Underwriting and Investment, part 3, Analysis of Expenses, indicates the percentage of actual claim adjustment expenses to paid claims for 1995 is approximately one percent. A four to six percent provision would be more reasonable and comparable with the health

care industry. It is recommended the Company review its allocation methodology to determine if it has correctly identified and captured all claim adjustment expenses.

Managed Care Capitation Arrangements

The Company is aggressively moving into a managed care environment. Under managed care, provider contracts are set up on a capitation basis such that the provider assumes the risk of the subscribers medical care for a monthly capitation payment. These monthly capitation payments are deposited in capitation pools that are established to pay for primary and specialty care which the provider provides or refers out. The provider is responsible for the management of the fund dollars and, is at risk for any deficit.

The Company keeps a portion of the monthly premium for the administration of claims and out of area emergent care. The remaining premium becomes the monthly capitation payment to the provider. If a surplus is generated in these funds, it is distributed back to the provider as incentive for efficient (lower than expected) utilization. These arrangements bring up some important questions in relation to the transfer of risk to non-insurance entities and reserves for that risk.

If a provider was faced with adverse selection due to unforseen circumstances, the provider would be inclined to imprudently limit care or run large deficits that the provider cannot absorb. In this scenario, the Company would be required to underwrite losses for which no reserves would be available. Consequently, this may subject the Company to a financially vulnerable position. Managed care arrangements are gaining larger market shares at an increasingly fast pace. It is recommended that the Company review the need to establish contingency reserves.

Contingent Liabilities

Lease obligations

All leases are classified and recorded as operating leases per the Ernst and Young, LLP, 1995 Report of Independent Auditors. This report also indicates that future minimum lease payments under non-cancelable leases at December 31, 1995 are:

1996	$	489,000
1997		489,000
1998		418,000
1999		155,000
Total	$	1,551,000

Litigation

The Company is involved in various legal actions in the normal course of business, some of which seek substantial monetary damages, including claims for punitive damages that are not covered by insurance. The Company's management believes that any liability in excess of that accrued would not materially affect the Company's financial position or results of operation.

III. MARKET CONDUCT

Claims Compliance Testing

A review of the Claims Operation was conducted by reviewing claim practices and procedures with management, and by reviewing a small sample of paid claims. In general, the claims operation was determined to be working well, with claims processing averaging less than thirty days from receipt to payment. Controls appear to be adequate to assure proper adjudication of claims. An error ratio of approximately 6% was found in the sample reviewed.

Subrogation

The procedure calls for the processor to determine if a possible subrogation exists. The instructions include a list of both procedure and diagnostic codes that indicate possible subrogation cases. Some cases may exist in which further investigation is required and some cases in which the company elects to pay the claim and then pursue reimbursements. The second is more common if the amount is under $500. In reviewing claims, we found that this procedure is not always followed. If the amount is less than $500, the usual procedure may be to pay the claim and not pursue additional information.

Coordination of Benefits (COB)

Written procedures exist for processing coordination of benefits. The instructions include how to identify COB, how to process, order of benefit determination and follow up. COB savings must be calculated manually and are stored on the notepad of the claims system. Explicit instructions are in place on how to make the calculations and how to enter the information on the notepad.The procedures seem to be complete and comply with Chapter 284-51WAC in all areas but one. 284-51 WAC -090 and -100 allow the company to take a reasonable amount of time to establish the existence of other coverage and to determine amount available. However, it also requires that the Company pay the claim if this information is not obtained within a reasonable time period. PacifiCare instructs processors to deny claims if the requested information is not received within the 30 day period established in the procedures.

The claim review also indicated that for a period of time, the Company was sending original claim

forms to providers for authorization based on capitated provider contracts. In many instances, the form was not returned or it was returned as a duplicate billing. This created both incomplete claim records and extra work for processors working on duplicate billings. This practice of returning original claim forms to medical groups for authorization is no longer being used.

Member Contracts

A sample of contract files for eight current groups was selected during the examination. This review included the following steps:

1. Compare contract forms issued to the master contract to ensure that all benefits requested were issued.

2. Compare contract forms issued to the most current OIC information to ensure that all contracts issued were not disapproved by the OIC prior to being issued.

3. Review the contract provisions to ensure that all required benefits are included in the contract, and that all rules and regulations were followed concerning contract format and language.

The Company did not file negotiated (non-standard) contracts during 1995. WAC 284-44-130 (2) requires that all negotiated contracts and rates be filed within 30 days after completed negotiations. The Company is instructed to file all negotiated contracts within the limits as stated in WAC 284-44-130(2).

The member handbook, MH-1 does not include language required by WAC 284-51-150(2). This regulation requires companies to include a statement in the coordination of benefits section of the handbook that instructs members to file claims with all carriers simultaneously. The Company was instructed to include this language in all member handbooks.

It was noted that the Company was lax in obtaining signatures on contracts during 1995, by either obtaining signatures late (6 months after the effective date) or not at all. In 1996, the Company changed the contract format so that signatures were required only on the application. The application which has the required signatures is now made a part of the contract. It is recommended the Company obtain the signature of the designated party entering into the contract in order to perfect a valid contract, and ensure that required signatures are obtained in a timely manner.

The member handbook contains a variety of references to different types of providers. It is confusing and hard to determine which type of provider the company is referring to in the booklet. It is recommended that the Company revise its provider definitions where possible, and simplify the language describing providers in the handbook.

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Rate and Form Filings

A sample of selected filings were reviewed for the Company. The sample disclosed negotiated contracts were not filed within 30 days of the date the negotiations with the group are completed as required by WAC 284-44-130. WAC 284-44-130(2) applies to contracts, riders, endorsements and rates. Negotiated groups from mid 1994 through mid 1996 were not filed in accordance with the regulation. The reason given for this oversight was a lack of staff who were able to perform this function, and the extra workload created by mergers with other health care service contractors. These groups were filed in May of 1996, and a follow up system has been established to ensure that this does not happen again in the future.

Provider Contracts

The examination of provider contracts consisted of reviewing the provider contracts currently in use. A sample of fourteen files was selected for review to ensure that only approved contract forms were used in contracting. All contract forms include a separate page that has been approved by the OIC which contains all language mandated by WAC 284-44-240. No instances were found in which an unapproved form was in place. In addition, the Company files provider listings and updates as required by RCW 48.44.080.

The examiners' only concern was that the Company was unable to produce a complete listing of contracted providers for review during the examination. The listing was produced and filed with the Annual Statement as required, but it was not saved and could not be reproduced during our examination. It is recommended that the procedures used to produce this report be recreated and saved. The Company has a responsibility to produce this information for regulators, employer groups and members upon request.

Complaints

Complaints are received in the mail room and opened. Any mail that looks like an OIC complaint is identified as such and sent to Appeals and Grievances. Once received by A&G, the complaint is logged, and a screen print is done to start the file. All claim information is put into the file and sent to appropriate parties for review.

Some capitated medical groups are responsible for provider payments under special agreements. The Company does not, however, delegate any complaint handling to the groups. All decisions on disputed claim handling are resolved at the Company level.

Complaints are divided into 4 categories:

1. Commercial Appeal: A written request for reconsideration of a previously denied claim. In most cases, the claim was denied because the Company determined that the

services were not covered under the contract. This complaint category goes beyond a general request for information, and expresses both dissatisfaction with and non-acceptance of the prior resolution.

2. Commercial Grievance: A written complaint regarding service delivery issues other than denial of reimbursement for medical services or denial of medical services.

3. Provider Inquiry: A written complaint regarding provider services.

4. Complaints: Requests or comments about non-financial issues, such as "id" cards, phone wait time, and other interactions with the Company or provider.

All of the above are kept in separate logs. In addition, PCW summarizes information about each category on a monthly basis. This information is passed along to the appropriate parties including the board, executives, and managers.

The Company maintains an Appeals and Grievances Policies and Procedures manual. This manual contains instructions on handling of both appeals and grievances. The Company does not provide a similar process for provider inquiries or complaint categories. An Appeals and Grievances Committee meets monthly to monitor complaint handling and to ensure that timely service is maintained.

There were 46 OIC complaints during the first six months of 1996. The majority of these, 33 were concerning claim handling, 12 were policyholder servicing and 1 was underwriting. The total for the same period in 1995 was 11 complaints. During 1995, PCW experienced a large increase in enrollees due to its purchase of another health carrier. The Company acknowledged that it was not prepared for the influx of new members and not ready to handle the volume. It also was working on a new computer system during this time, which added to delayed claim payments.

The Company records indicate that there were about 700 complaints of all types for all lines of business, thru June 1996. The Company keeps monthly statistics based on a pro rated percent of complaints per 1000 members. This data shows that complaints have increased over the previous year, but are constant for the current year. In addition, the Company also keeps records on types of complaints and the number of reversals.

The number of decision reversals is high. It appears that the claim processor lets the system edit claims, and does not override or investigate any questionable claims. Therefore, any extenuating

circumstances or special handling situations are automatically denied. This increases the number of appeals and grievances filed with the Company. At this time, these decisions are handled with a full appeal procedure. The Company is looking at giving processors and customer service representatives the ability to make exceptions up front to avoid the appeal/grievance process.

Conclusion

PacifiCare has a viable process for handling complaints and grievances. Review of both OIC complaints and non-OIC complaints shows that the Company does follow their procedures and gives the same type of consideration to both OIC and non-OIC complaints. All files are well documented. Letters to complainants are usually thorough and explain the reason for a decision, either positive or negative.

PacifiCare of Washington

AFFIDAVIT OF EXAMINER IN CHARGE

STATE OF WASHINGTON)
)ss
COUNTY OF KING)

Michael V. Jordan, being duly sworn, deposes and says that the foregoing report subscribed by him is true to the best of his knowledge and belief.

He attests that the examination of PacifiCare of Washington was performed in a manner consistent with the standards and procedures required or prescribed by theWashington Office of the Insurance Commissioner and the National Association of Insurance Commissioners (NAIC).

Michael V. Jordan, CPA, CFE
Examiner-in-Charge
State of Washington

Subscribed and sworn to before me this 17th day of April, 1997.

Colleen Jansen
Notary Public in and for the
State of Washington, residing
at Seattle.